# Kansas Attorney General
# Derek Schmidt

**Division of Crime Victims Compensation**
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**Claim# _____**
(for DCVC office use only)

## APPLICATION FOR CRIME VICTIMS COMPENSATION

***Must be filed within two years of incident. Cases of child sexual assault are based on the date the crime was reported to law enforcement. It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305(b).***

Questions regarding financial stress are required by Kansas Statute.

**Please check the type(s) of crime victim compensation for which you are applying:**

**☐ Medical ☐ Counseling ☐ Loss of wages ☐ Funeral ☐Crime Scene Clean-up ☐ Clothing/Bedding ☐ Moving**

### Section A – VICTIM INFORMATION *(Person who was injured)*

| 1. Victim's First Name: | 2. Middle Name: | 3. Last Name: | |
|---|---|---|---|
| 4. Victim's Date of Birth: | 5. Victim's Age: | 6. Victim's Social Security Number | |
| 7. Address: | 8. City: | 9. State: | 10. Zip Code: |
| 11. Daytime Telephone: | 12. Cell Phone: | 13. Other Phone: | |

***13. The following information is optional and will be used for statistical purposes only and is requested to comply with Federal Civil Rights Act under Section 1407(e) of the Victims of Crimes Act of 1984.***

| **A. Handicapped:** | **B. Race:** | | **C. How did you find out about this program?** | | **D. Sex:** |
|---|---|---|---|---|---|
| ☐ Yes<br>☐ No | ☐ White<br>☐ Black<br>☐ Hispanic | ☐ American Indian/ Alaskan Native<br>☐ Asian/Pacific Islander<br>☐ Other _____ | ☐ Police<br>☐ Hospital<br>☐ Prosecutor<br>☐ Other (please specify)_____ | ☐ Victim Assistance Program<br>☐ Poster/Brochure<br>☐ Public Service Announcement | ☐ Male<br>☐ Female |

### Section B – APPLICANT (CLAIMANT) INFORMATION
***(Complete this section if victim is a minor, incapacitated or deceased)***

| 1. Claimant's First Name: | 2. Middle Initial: | 3. Claimant's Last Name: | 4. Claimant's Relationship to Victim: |
|---|---|---|---|
| 5. Claimant's Mailing Address: | 6. City: | 7. State: | 8. Zip Code: |
| 11. Daytime Telephone: | 12. Cell or Other Phone: | 11. Claimant's Social Security Number: | |

### Section C – ATTORNEY REPRESENTATION: Are you represented by a private attorney in a civil lawsuit or insurance action *as a result of this incident?* ☐ **Yes** ☐ **No.** *If **yes,** please complete the following:*

| 1. Attorney's Name: | 2. Attorney's Telephone Number: | |
|---|---|---|
| 3. Firm Name: | | |
| 4. Mailing Address: | 5. City | State Zip Code: |

Victim Name: _____,_____

## Section D – CRIME INFORMATION

**1. Type of Crime:** ***(please check one)***

| | | |
|---|---|---|
| ☐ Domestic Violence<br>☐ Domestic Violence (homicide)<br>☐ Sexual Assault/Rape (adult)<br>☐ Child Sexual Abuse<br>☐ Child Physical Abuse | ☐ Assault<br>☐ Kidnapping<br>☐ Stalking<br>☐ DUI<br>☐ DUI/Homicide | ☐ Murder/Homicide<br>☐ Robbery<br>☐ Arson<br>☐ Other (please specify)<br>_____ |

| | | |
|---|---|---|
| 2. Date of Crime: | 3. Date Crime Reported: | 4. Name of Law Enforcement Agency Reported to: |
| 5. Police Report # | 6. Investigating Officer's Name: | |

7. Brief Description of Crime:

| | | | |
|---|---|---|---|
| 8. Location of Crime - Street Address: | City: | County: | State: |

9. Name(s) of Offender(s):

| | |
|---|---|
| 10. Did victim know offender(s)?<br>☐ **Yes** ☐ **No** | ***If yes, in what way?*** |

11. Has an arrest been made? ☐ Yes ☐ No ☐ Unknown

| | |
|---|---|
| 12. **Court Case #:** | ☐ **District Court**<br>☐ **Municipal Court** |

## Section E – FUNERAL/BURIAL EXPENSES *(Maximum allowable is $5,000.00 )*

**Are you seeking funeral benefits for a deceased victim?** ☐ **Yes** ☐ **No** ***If yes****, complete* ***Section E*** *and attach copies of bills.*

** Applications for grief therapy for family members are available. Please contact our office for details.

1. Name of Funeral Home:

2. Street Address:

| | |
|---|---|
| 3. City, State, Zip Code: | 4. Telephone Number: |

5. Total amount of *funeral* expenses $ _____ Total amount of *burial* expenses $ _____

6. Have funeral and burial expenses been paid? ☐ **Yes** ☐ **No** ***If yes,*** by whom?_____

7. Will applicant receive funeral payment or death benefits from any of the following? ☐ **Yes** ☐ **No** ***If yes***, amount:

Social Security $_____ Insurance $ _____ Donations $_____

Workers Compensation $_____ Other (describe) $_____

Victim Name: _____,_____

**Section F – LOSS OF SUPPORT** ***(Maximum allowable $400.00 per week.)***

Have you or any dependent children sustained loss of financial support resulting from the *death* of the victim?
☐ **Yes** ☐ **No** ***If yes,*** *complete Section F.*

| ***Dependent's Name*** | ***Date of Birth*** | ***Social Security Number*** | ***Relationship to Victim*** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Section G – MEDICAL INFORMATION** ***(All information confidential pursuant to K.S.A. 74-7308.)***

List all medical expenses incurred as a result of this incident, including hospital and doctor charges, ambulance fees, x-rays and prescriptions.

***** Please attach itemized statements or bills, receipts and insurance statements if they are available.***

| ***Name of Medical Provider*** | ***Address*** | ***City and State*** | ***Zip Code*** | ***Telephone*** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Briefly describe victim's injuries:**

**Section H – COUNSELING INFORMATION**

***** Please attach itemized statements or bills, receipts and insurance statements if they are available.***

| **MENTAL HEALTH INFORMATION** | | | | **Person receiving counseling and their relationship to victim** |
|---|---|---|---|---|
| ***Counselor/Organization*** | ***Address*** | ***City and State*** | ***Zip Code*** | |
| | | | | |
| | | | | |
| | | | | |

**Section I – OTHER EXPENSES: (Clothing/Bedding seized as evidence, Crime Scene Clean-up, Relocation)**
***All expenses are subject to approval***

| ***Description*** | ***Amount*** | ***Description*** | ***Amount*** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Victim Name: _____,_____

## Section J -- WAGE LOSS

| | |
|---|---|
| Was victim employed at the time of the incident? ☐ Yes ☐ No<br>Did victim miss work and pay because of injuries? ☐ Yes ☐ No | ***If you answered yes to both of these questions, please complete Sections J and K*** |

| | | | |
|---|---|---|---|
| **Employer's Name:** | | | |
| **Employer's Mailing Address:** | **City:** | **State:** | **Zip Code:** |

| | |
|---|---|
| **How long was victim medically disabled and off work as a result of the incident?** | **From _____ to _____**<br>**(date) (date)** |
| **What dates, if any, were covered by victim's accrued vacation/sick leave?** | **From _____ to _____**<br>**(date) (date)** |

| | | | |
|---|---|---|---|
| **Name of Doctor who can verify length of disability to work:** | | | |
| **Doctor's Street Address:** | **City:** | **State:** | **Zip Code:** |

**** Applicants for wage loss must attach a copy of their latest Federal Income Tax Return.**
**Compensation may be awarded at a maximum rate of $400.00 per week for unreimbursed wage loss.**

## Section K -- SOURCES OF INCOME *(Complete only if applying for wage loss.)*

Indicate below ***all*** other sources of income you received during period of wage loss, such as:
❑ Workers Compensation, ❑ Unemployment Compensation, ❑ Public Assistance, ❑ Social Security or ❑ Other income:

| Income Source (Description) | Name and Address of Payer | Income Amount | How Often |
|---|---|---|---|
| | | $ | |
| | | $ | |
| | | $ | |

## Section L -- INSURANCE/COLLATERAL SOURCES -

**Please check all available sources that could be applied to your claim.**

**LIST INSURANCE INFORMATION BELOW.** ❑Health/Life Ins., ❑Automobile Ins., ❑Medicaid, ❑Medicare, ☐ Burial Ins.
❑Veterans Administration, ❑Armed Services (CHAMPUS), ❑Workers Compensation, ❑Social Security, ❑Other Sources.

| Name/Type of Source | Name and Address of Source | Policy/Claim Number |
|---|---|---|
| | | |
| | | |
| | | |

Victim Name: _____,_____

**Section M -- CERTIFICATION OF FINANCIAL HARDSHIP *(Required by K.S.A. 74-7305(d))***

I (claimant) affirm the customary level of health, safety and education for self and dependents cannot be maintained without undue hardship as a result of the incident upon which this claim is based.

**Section N -- ASSIGNMENT OF BENEFITS**

***(1) Medical care expenses*** -I hereby assign any compensation awarded for unpaid medical care to the applicable medical care provider. This assignment is conditional that such provider agrees to accept a direct payment from the Kansas State Treasurer to pay 80% of allowable charges as satisfaction of payment in full. I authorize the Kansas State Treasurer to pay 80% of such allowable unpaid medical charges to the appropriate medical care provider.

***(2) Non-medical care expenses*** - I hereby assign any compensation awarded for unpaid non-medical care charges to the applicable provider. I authorize the Kansas State Treasurer to pay any such allowable unpaid non-medical charges directly to the provider.

**Section O -- CERTIFICATION OF CLAIM**

I hereby certify, subject to the penalty of fine or imprisonment, that all losses claimed herein are a direct result of the crime and that the information contained in this application for an award is true and correct to the best of my knowledge and belief.

**Section P -- PROMISE TO REPAY**

Pursuant to K.S.A. 74-7312, I promise to repay the Kansas Crime Victims Compensation Fund, through the Crime Victims Compensation Board if I receive payments from the offender (restitution or civil action), insurance or any other government or private agency resulting from this incident.

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

I authorize and request any person having information with respect to the incident leading to the victim's personal injury or death necessary to the administration of this claim, including all past law enforcement records, to release that information to the Crime Victims Compensation Board, or its representative. This release includes but is not limited to, private and governmental physicians and hospitals; local, state and federal law enforcement and prosecutors offices; local, state and federal court personnel, any employer; any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I hereby agree and certify that no person shall incur any legal liability by releasing any information pursuant to this authorization. A photocopy of this authorization is effective and valid as the original. All information obtained by the Board will remain confidential pursuant to K.S.A. 74-7308 and amendments thereto.

_____

(Claimant's Signature)

_____

(Print name)

for _____

***(If victim is 12 years or older, they must sign on this line.)***

Date _____

***** If you have not received a letter within two weeks of mailing this application, please call (785) 296-2359 to verify that the application has been received.***

Victim Name: _____,_____

## Office of the Kansas Attorney General
## *DIVISION OF CRIME VICTIMS COMPENSATION*

### APPLICATION FOR CRIME VICTIMS COMPENSATION AND ELIGIBILITY REQUIREMENTS

If you have been an innocent victim of a violent crime and have suffered financial losses that are not covered by insurance or any other source, the Kansas Crime Victims Compensation Fund may be of assistance to you. The State of Kansas is committed to helping victims who meet the eligibility requirements of the Kansas Crime Victims Compensation Act. While no amount of financial aid can erase the trauma of crime, it is the goal of this program to ease the aftermath of crime for the victim whenever possible.

**Eligibility Requirements:**

1. *Must be filed within two years of incident. Cases of child sexual assault are based on the date the crime was reported to law enforcement. It is the claimant's responsibility to establish proof that the claim was filed timely pursuant to K.S.A. 74-7305(b).*
2. *Victim suffered bodily injury (including mental disorder or death) as a victim of a violent crime.*
3. *The incident occurred in Kansas, or outside the United States to a Kansas resident.*
4. *The incident was reported to law enforcement officials within 72 hours, or would have been reported within that time except for a valid reason.*
5. *The claimant (and/or victim) fully cooperated with law enforcement officials during their investigation and prosecution.*
6. *Economic loss (medical expenses, wage loss, etc.) will total $100.00 or more and has not been (or will not be) totally paid by other sources except in cases of sexual abuse.*
7. *The victim was not an accomplice to and did not commit a crime in connection with this incident (e.g. gang activity, drug dealing.) Victim must not have provoked or caused the injury or death.*

**KANSAS STATUTE AUTHORIZES THE BOARD TO REDUCE OR DENY CLAIMS THAT INVOLVE THE VICTIM'S CONTRIBUTORY MISCONDUCT OR PARTICIPATION IN UNLAWFUL ACTIVITIES.**

**Eligible and Ineligible Expenses:**

- *Medical expenses not covered by other sources are eligible expenses.*
- *Reasonable costs for replacement of clothing and bedding seized as evidence are compensable.*
- *Victims or claimants who are required to testify in sexually violent predator cases may be eligible for compensation for mental health counseling.*
- *Property loss, property damage and pain and suffering are ineligible expenses.*

**Award Maximums:**

- *Overall maximum award of $25,000.*
- *Funeral expense maximum of $5,000.*
- *Grief therapy for family members of homicide victims is available. Call for separate grief therapy application.(Maximum award is $1,500.)**
- *Outpatient mental health counseling maximum of $5,000.**
- *Inpatient mental health care maximum of $10,000.**
- *Lost wages/loss of support maximum of $400 per week.*
- *Crime scene clean-up maximum of $1,000.*

***Additional compensation may be awarded based on extenuating circumstances.***

***HOW TO FILE YOUR APPLICATION FOR COMPENSATION***

Read all instructions for each section before completing this application. Please provide all information requested. Applications which are not completed and signed will be returned, thus delaying a decision on your claim. Please include copies of your medical bills and other expenses. Once your completed application is received and all requests for additional documents and information have been received and reviewed, you will be notified in writing of the Board's decision. You have the right to appeal that decision if you disagree

***The complete application process takes approximately 3 months.***

**If you have any questions while completing the application, please call our office at (785) 296-2359**